AVIATION AND SPECIAL DUTY PERSONNEL PRK APPLICATION FORM

(Read Instructions before completing form - NOT for Warfighter PRK applicants)

INSTRUCTIONS. ***THIS FORM IS FOR AVIATION AND SPECIAL DUTY PRK APPLICANTS ONLY.***

1. Print or type all information in sections 1-14 on both pages of this form.

*2. Enter all dates in the format **dd/mmm/yy** (01/Aug/02).*

3. Applicant's initials are required in section 12. (a.b.c)., "REQUIRED QUESTIONS."

*4. Applicant **must discontinue** hard contact lenses **for at least 90 days,** or soft contact lenses **for at least 30 days prior to REFRACTION, KERATOMETRY and CORNEAL TOPOGRAPHY** (See section 3.c.d. 4.a.b. and 8.).*

5. CORNEAL TOPOGRAPHY should be in axial or tangential view, not sagittal, 0.50 D increments, standard scale, not auto scale.

(Additional instructions can be found on the Optometry website: http://chppm-www.apgea.army.mil/dcpm/vision/airforce/bbdefault.asp)

6. MAKE FILE COPIES.

Mail original completed form, original corneal topography, and supporting documents to:

USAFSAM/FECO, Attn: USAF PRK Registry
2507 Kennedy Circle
Brooks City-Base, TX 78235-5116

*7. **NO PHOTOCOPIES OR FAX'S ALLOWED.** Incomplete forms will be returned. Allow three weeks for processing.*

8. Reply letter will be mailed to the local Flight Surgeon Office (FSO). Please insure section 14 is complete.

1. TO BE COMPLETED BY APPLICANT: (1.a. through v.)

Date of Application: **(Format: dd/mmm/yy)**				s. Applicant's Home Address: Street:
a. Last Name:	First Name:	MI:	Suffix:	City: State:
b. SSAN:	c. Date of Birth:		d. Age:	Zip: Country: Phone: (Commercial)
e. Sex: ☐ Male ☐ Female	f. Grade (E-/O-):	g. Primary AFSC:		Home email:
h. Duty Status: ☐ Active ☐ AFRes ☐ AGR ☐ ANG ☐ Other		i. MAJCOM:		t. Applicant's Duty Address: Unit:
j. Crew / Duty Position:		k. Actively Flying? ☐ Y ☐ N		Street: Base:
l. Aviation Service Code:	m. Current Aircraft of Assignment:			State/APO: Zip: Phone: (Commercial) (DSN)
n. Total # of Military Flying Hours:	o. Total # of Hours in the Last 6 Mo.:			Duty email:
p. Date completed UPT (Pilots only):	q. Rated Years of Service (Pilots only):			u. Planned PRK surgery location:
r. Total months retainability (ADSC): (*Must have at least 12 months after PRK date*)				v. Applicant's Signature:

2. TO BE COMPLETED BY APPLICANT'S COMMANDER: (2.a.through f.)

a. Name/Rank of Commander:	b. Commander Approval: ☐ Yes ☐ No	c. Date:

d. Review non-medical data, PRK Policy Letter (SG Policy # 00-005, 2 Aug 00), initial 1 and 2 below, and sign form at "f."

Initial	*1. "Approval" indicates commander has assessed the operational impact of the individual's request for PRK treatment and follow-up on mission requirements. It further indicates that local unit funding support for this procedure is assured for treatment and all follow-up examinations. Leave or permissive TDY for PRK is currently not allowed.*
Initial	*2. Commander's initials confirm member qualifies under Aviation and Special Duty PRK policy SG #00-005 and AFMOA/CV PRK Policy Letter 1 Jul 02, **and** will have 12 months retainability **after** PRK surgery date.*

e. Duty Phone: _____ (Commercial) (DSN)	f. Signature:

TO BE COMPLETED BY USAFSAM/FECO: ("PERMISSION TO PROCEED") (FOR USAFSAM REVIEWER ONLY)

Name/Rank of Reviewing Officer:		Date of Review:
Permission to Proceed: ☐ Yes ☐ No	Comments: (See "Permission Letter")	Signature:

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Last Name:	SSAN:	Application Date:

TO BE COMPLETED BY THE MILITARY OPHTHALMOLOGIST/OPTOMETRIST OR FLIGHT SURGEON:

3. REFRACTIVE DATA: Complete all fields and dates.

a. # of days contact lenses not worn prior to exam:
SEE INSTRUCTION #4 ON PAGE ONE

b. Uncorrected Acuity:

	Distance		Near	
OD	20/		20/	
OS	20/		20/	

c. Manifest Refraction: **Date:**

OD		-		**x**		=20/	
OS		-		**x**		=20/	

d. Cycloplegic Refraction: **Date:**

OD		-		**x**		=20/	
OS		-		**x**		=20/	

e. Prior Refraction #1 (not lensometry) **Date:**

OD		-		**x**		=20/	
OS		-		**x**		=20/	

f. Prior Refraction #2 (not lensometry) **Date:**

OD		-		**x**		=20/	
OS		-		**x**		=20/	

4. KERATOMETRY: (two readings/dates at least 1 week apart)

a. 1st reading: Normal Mires Y / N **Date:**

OD		@			@	
OS		@			@	

b. 2nd reading: Normal Mires Y / N **Date:**

OD		@			@	
OS		@			@	

5. CONTACT LENSES: (any previous) **Date:**

	TYPE	POWER	DIA	BC
OD				
OS				

6. SLIT LAMP EXAM: **Date:**

(Circle one. If ABNL, explain below in Comments)

OD NL / ABNL
OS NL / ABNL

IOP OD
(TA) OS

7. DILATED FUNDUS EXAM: **Date:**

(If ABNL, explain below in Comments)

OD NL / ABNL
OS NL / ABNL

8. CORNEAL TOPOGRAPHY: **Date:**

(Review Instruction #4 and #5 on Page 1)

OD NL / ABNL
OS NL / ABNL

9. PUPIL SIZE: Use either option a. or b.

a. Infrared Pupillometry (Colvard/Keeler/etc. with room lights off)
OD mm OS mm

b. BOTH (1) and (2) REQUIRED

(1) Humphrey Visual Field Tester (room lights off)
OD mm OS mm

(2) PD Ruler (just enough room light to see pupils)
OD mm OS mm

10. ADDITIONAL COMMENTS: (attach if needed)

11. EXCLUSION CRITERIA:

a. Age < 21: No/ Yes/ Unkn
b. > 0.50 D change in sph, cyl or K's in past 1 year: No/ Yes/ Unkn
c. From Cycloplegic Refraction (Section 3.d):
1. < -1.00, > -8.00D any meridian (-5.50 pilot): No/ Yes/ Unkn
2. Any Hyperopia in any meridian: No/ Yes/ Unkn
3. Greater than -3.00 diopter cylinder: No/ Yes/ Unkn
d. Corneal scars in central 8 mm of cornea: No/ Yes/ Unkn
e. Corneal NV > 2 mm from limbus: No/ Yes/ Unkn
f. PDS or IOP greater than 22: No/ Yes/ Unkn
g. Uveitis, cataract, or glaucoma: No/ Yes/ Unkn
h. Keratoconjunctivitis sicca/ Excessive dry eyes: No/ Yes/ Unkn
i. Hx of previous refractive surgery: No/ Yes/ Unkn
j. Chronic or recurrent conjunctivitis: No/ Yes/ Unkn
k. History of HSV / HZV keratitis: No/ Yes/ Unkn
l. Keratoconus or family history of keratoconus: No/ Yes/ Unkn
m. Diabetes mellitus / Thyroid disorder: No/ Yes/ Unkn
n. Collagen-vascular / Autoimmune disease: No/ Yes/ Unkn
o. Use of Accutane (Isotretinoin) in the past 6 months; Cordarone (Amiodarone) past 1 year; Imitrex (Sumatriptan) past 1 month; or Steroids: No/ Yes/ Unkn
p. Pregnancy / active nursing: No/ Yes/ Unkn
q. Any unrealistic expectations? (Explain in Comments) No/ Yes/ Unkn
r. Any other exclusions? (Explain in Comments) No/ Yes/ Unkn

12. REQUIRED QUESTIONS: (Applicant must initial a.b.c.)

a. Does patient understand that they may need to wear glasses or contact lenses after PRK and that contact lenses may not be wearable after PRK? ☐ Yes ☐ No Init:
b. Does patient understand that reading glasses **WILL** be needed after PRK even if not needed now? ☐ Yes ☐ No Init:
c. Does patient understand they may not be waiverable for flying duty after PRK? ☐ Yes ☐ No Init:
d. Any history of trauma that might impact PRK? ☐ Yes ☐ No
e. Other pertinent ocular history? ☐ Yes ☐ No
(If yes, explain / Dx in "Additional Comments" or attachment)
f. In your professional opinion does the patient meet PRK criteria? ☐ Yes ☐ No
g. Will there be a DoD certified PRK eye practitioner available for post-operative care? ☐ Yes ☐ No

13. SIGNATURE AND STAMP OF EXAMINER:

Base:
Phone: (DSN)
Name/Rank or Stamp:

MD/DO/OD Signature:

14. FLIGHT SURGEON INFORMATION: (Signature required)

Unit / Office Symbol:
Street address:
Base:
State (or APO) : Zip +4:
Phone: (Commercial)
(DSN)
Name/Rank:
FS Signature: